PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED	
155199		B. WING		08/01/2012	
				ADDRESS, CITY, STATE, ZIP CODE	ı
NAME OF I	PROVIDER OR SUPPLIE	R		UNION ST	
MAPLE F	PARK VILLAGE			FIELD, IN 46074	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG			TAG	DEFICIENCY)	DATE
K0000					
	A Quality Assur	rance Walk-thru Survey	K0000	August 14, 2012	
	was conducted by the Indiana State				
	Department of I	Health.			
				Please find the attached plan of	
	Survey Date: 08	8/01/12		corrections for the Survey Event ID	
	Survey Date. 0	0/01/12		MM1U21 performed on August 1,	
				2012. The provider respectfully	
	Facility Number			requests that the 2567 plan of	
	Provider Number	er: 155199		correction be considered the letter	
	AIM Number: 100266390			of credible allegation and requests	
				desk review, in lieu of a post survey	
	Surveyor: Mark	c Caraher, Life Safety		revisit.	
	Code Specialist				
	Code Specialist			Sincerely,	
	A	A 337 11 41			
	1	Assurance Walk-thru		7ach Krumusiad UFA	
		Park Village was found not		Zach Krumwied, HFA Executive Director	
	in compliance w	vith 410 IAC		Maple Park Village	
	16.2-3.1-19(ff).			Widple Falk Village	
	This one story f	acility was determined to		The creation and submission of this	
	_	11) construction and fully		plan of correction does not	
	, , , , , , , , , , , , , , , , , , ,	· ·		constitute an admission by this	
		e facility has a fire alarm		provider of any conclusion set forth	
	_	oke detection in the		in the statement of deficiencies, or	
	corridors and ar	eas open to the corridors.		any violation of regulation.	
	The facility doe	s not have smoke		,	
	detectors in resi	dent sleeping rooms. The			
		pacity of 106 and had a			
		the time of this visit.			
	The facility was	found in compliance with			
	_	ard to sprinkler coverage			
	_	not in compliance with			
		_			
	State law III lega	ard to smoke detector			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
155199			LDING	01	08/01/		
		100100	B. WIN		DDDDGG GYMY GMARD GYD GODD	00/01/	2012
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST				
MAPLE PARK VILLAGE					IELD, IN 46074		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	coverage.						
	All areas where access were spri	residents have customary nklered.					
	The facility has	two detached storage					
	_	ing facility services					
	which are not sp	-					
	winesi are not sp	inimiorou.					
	Quality Review by	Lex Brashear, Life					
		alist-Medical Surveyor					
	on 08/01/12.						
	The facility was found not in compliance with the aforementioned regulatory						
	requirements as evidenced by the						
	following:						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MM1U21

Facility ID: 000106

If continuation sheet

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PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE (CONSTRUCTION 01	COMPL	
THEFTERN	155199		A. BUII			08/01/	
		100100	B. WIN		Γ ADDRESS, CITY, STATE, ZIP CODE	00/01/	
NAME OF PROVIDER OR SUPPLIER					UNION ST		
MAPLE PARK VILLAGE					FIELD, IN 46074		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5)
PREFIX						ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K9999							
	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS		K9999		#1 No specific resident was		08/22/2012
					identified as being affected by the deficient practice.		
					#2 All residents have the potential	to	
					be affected by the deficient practic	e.	
	2 1 10/ff) A hast	th facility licensed under			Smoke detectors with a 10 year		
	` '	th facility licensed under the must do the following:			lithium battery will be installed in 5	8	
		· ·			of 58 resident rooms. #3 The Maintenance Director will		
	(1) Have an automatic sprinkler system installed throughout the facility before				perform rounds after the installation	n	
	_	out the facility before			of the smoke detectors in 58 of 58		
	July 1, 2012.				rooms to ensure function and		
	(2) If an automatic sprinkler system is not installed throughout the health care				placement is compliant.		
	_				# 4To ensure compliance, the		
	facility before July 1, 2010, submit before				Maintenance Director/Designee is		
		an to the department for			responsible for the completion of the Smoke detector CQI audit tool		
	completing the in				weekly x 4 weeks, monthly x 2		
	•	ler system before July 1,			months, and then quarterly until		
	2012.				continued compliance is maintained	d	
	(3) Have a battery operated or hard-wired				for 2 consecutive quarters. The		
	smoke detector in each resident's room				results of these audits will be		
	before July 1, 20	12.			reviewed by the CQI committee		
					overseen by the ED, If threshold of 95% is not achieved an action plan		
	This State Rule has not been met as				will be developed to ensure		
	evidenced by:				compliance.		
		ation and interview, the			#5 Compliance Date: 8.22.2012		
		install smoke detectors in					
		sleeping rooms before					
		is deficient practice					
	could affect 98 re	esidents in the facility.					
	Findings include	:					
	Based on observa	ations with the					

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Event ID: MM1U21

Facility ID: 000106

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A DUPLED DIC 01		(X3) DATE SURVEY COMPLETED			
155199			LDING		08/01/			
			B. WIN		DDRESS CITY STATE 710 CODE			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST					
MAPLE PARK VILLAGE			WESTFIELD, IN 46074					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
		rector during a tour of the						
		25 a.m. to 12:45 p.m. on						
		ke detector was not						
		of 58 resident sleeping						
		ility. Based on interview						
	at the time of the	e observations, the						
	Maintenance Dir	ector acknowledged a						
	smoke detector v	was not installed in all						
	resident sleeping	rooms in the facility.						
	3.1-19(ff)							
	5.1-15(11)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MM1U21

Facility ID: 000106

If continuation sheet

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